BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

STEVE ERICKSON, Appellant, v. DEPARTMENT OF VETERANS AFFAIRS, Respondent.	Case No. DISM-00-0024 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 **Hearing.** This appeal came on for hearing before the Personnel Appeals Board, WALTER T. HUBBARD, Chair; GERALD L. MORGEN, Vice Chair; and LEANA D. LAMB, Member. The hearing was held at the office of the Personnel Appeals Board in Olympia, Washington, on June 13, 14, and 22, 2001.

1.2 **Appearances.** Appellant Steve Erickson appeared *pro se*. Mitchel R. Sachs, Assistant Attorney General, represented Respondent Department of Veterans Affairs.

1.3 **Nature of Appeal.** This is an appeal from a disciplinary sanction of dismissal. Respondent alleges that Appellant failed to provide social service intervention to meet a resident's needs; failure to report the illegal phone use and charges of 1-900 number calls to the agency; untruthfully claimed that he met with the superintendent on August 18, 1999 to discuss the 1-900 number calls; failed to ensure that services were provided and documented in the file of a resident who committed

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suicide; and failed to complete or ensure that adequate documentation of services were made in resident charts in accordance with Veteran's Administration requirements.

1.4 **Citations Discussed.** WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983).

II. FINDINGS OF FACT

2.1 Appellant Steve Erickson was a Social Services Manager (Washington Management Service position) and permanent employee for Respondent Department of Social and Health Services at the Washington Veterans Home. Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal with the Personnel Appeals Board on March 29, 2000.

2.2 By letter dated March 8, 2000, Lourdes E. Alvarado-Ramos, Superintendent of the Washington Veterans Home, informed Appellant of his immediate suspension effective March 9, through March 23, 2000, followed by his immediate dismissal. Ms. Alvarado-Ramos alleged that Appellant failed to provide social service intervention to meet a resident's needs; failed to report the illegal phone use and charges of 1-900 number calls to the agency; untruthfully claimed that he met with her on August 18, 1999 to discuss the 1-900 number calls; failed to ensure that services were provided and documented in the file of a resident who committed suicide; and failed to complete or ensure that adequate documentation of social services provided were made in resident charts in accordance with Veterans Administration requirements.

2.3 Appellant began his employment as a Washington Management Service employee with the Washington Veterans Home in December 1994. The primary mission of the Washington Veteran's Home is to provide medical and supportive care for veterans who can no longer provide for

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themselves. Residents are eligible to receive rehabilitative care, with future plans to move back into the community, or they can elect to become long-term residents.

2.4 Appellant's responsibilities as a Social Services Manager primarily consisted of administering a social work program, developing and implementing social service policies and procedures and ensuring quality control in social work services. Appellant was part of the executive management team, and Superintendent Alvarado-Ramos directly supervised him. In addition to providing social services directly to residents, Appellant supervised other psychiatric social workers responsible for providing social services to residents. Appellant's caseload consisted of approximately 60 residents.

2.5 Appellant and his subordinates were responsible for conducting psychological assessments of residents and placing the assessments in their medical records. The assessments contained information on residents' social needs and plans for future services to be provided. The psychological assessments are to be reviewed and updated by a social worker annually. Social workers are also responsible for documenting the results of the social services provided and placing them in resident medical files on a quarterly basis. These standards and subsequent documentation are required by Veteran's Administration guidelines for Assisting Living and Domiciliary Care Standards and are critical to the mission of the agency as verification that residents are receiving appropriate care.

2.6 Ms. Alvarado-Ramos verbally counseled Appellant on numerous occasions and explained her expectations regarding Appellant's role and responsibilities. Ms. Alvardo-Ramos' objective was for Appellant to improve his performance and the performance of his department, which was perceived by other staff as being unresponsive to resident needs. Appellant acknowledged his understanding of Ms. Alvarado-Ramos' expectations.

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2.7 By memo dated January 27, 1999, Ms. Alvarado Ramos summarized a meeting she held with Appellant on January 7, 1999, related to a number of work issues. The memo addressed her concerns and expectations regarding Appellant's role as a Social Services Manager and reminded Appellant that he was expected to model professional behavior, exercise discretion and use independent judgment. Ms. Alvarado Ramos also emphasized to Appellant the necessity and importance of documenting social services provided.

2.8 Appellant also received the following corrective directives and disciplinary actions:

- By letter dated December 30, 1999, Superintendent Alvarado-Ramos, suspended Appellant for seven-days, alleging that on August 31, 1999, Appellant displayed inappropriate and unprofessional behavior in his communications with a resident guardian, made inappropriate comments about a subordinate and was actively involved in a vote of no confidence against the director of the Department of Veterans Affairs and Ms. Alvarado-Ramos. (PAB Case No. SUSP-00-0003).

- By letter dated October 28, 1999, Superintendent Alvarado-Ramos reprimanded Appellant for inappropriate comments he made regarding management during a new employee orientation and for his failure to provide her with a copy of the videotape made during the orientation. She warned Appellant that he could be subject to further corrective or disciplinary action if his inappropriate behavior continued.

- By letter dated August 25, 1999, Ms. Alvarado-Ramos outlined her concerns regarding Appellant's response to an email inquiry he received. Superintendent Alvarado-Ramos informed Appellant that his response was inadequate and not responsive and she directed Appellant to respond to inquiries in a professional manner.

2.9 Jane Burster, Health Information Consultant and Accredited Records Technician, is an independent contractor hired by the school to conduct audits of resident medical charts to ensure that the facility's operations are in compliance with state and federal regulations. Ms. Burster has

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been contracted by the Veteran's Administration since 1985. Ms. Burster examines the contents of residents' medical file, specifically noting whether they contained the requisite documents, including: medical findings, nursing assessments, care plans, rehabilitation evaluations, progress notes and social service evaluations.

2.10 In a 1998 audit, Ms. Burster concluded that the social services department was deficient by failing to consistently place updated psychosocial assessments in medical charts. In addition, she noted that there was a lack of follow-up documentation of social services rendered to residents. The audit reflected that there was adequate staffing for the patient population.

2.11 After reviewing the audit, Ms. Alvarado-Ramos became concerned with what she saw as significant problems in the social services department and the lack of proper documentation by Appellant and his social workers. She subsequently met with Appellant in July 1999, and discussed with him the importance of documenting social services rendered to residents. Appellant agreed to ensure that he and his staff maintained current assessments and progress notes in resident charts.

Incident involving Resident GM

2.12 Bill Engle, Certified Chemical Dependency Professional was contracted by the Veteran's Home as a Drug and Alcohol Counselor to conduct counseling and classes with residents. Resident GM was on Mr. Engle's caseload. On August 18, 1999, Mr. Engle visited GM because of GM's absences to his drug and alcohol classes. During the visit, GM told Mr. Engle that he was experiencing depression and feelings of isolation. During their discussion, GM told Mr. Engle that he had found a way to access a state phone line and was making 1-900 number sex calls. GM was not authorized by the agency to make these toll calls which were charged to the Veterans Home.

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2.13 Later that day, Mr. Engle met with Appellant and shared the details of his conversation with GM. Mr. Engle and Appellant visited GM that same afternoon. GM again expressed his feelings of isolation and his depression. GM described to Appellant how he accessed state phone line to make 1-900 toll phone calls. Appellant responded that he did not believe GM could make the calls, and he commented that GM "was going to have a very large phone bill." Appellant stated that he would follow-up with GM.

2.14 On September 8, 1999, Mr. Engle again visited with GM and during their discussion, GM indicated that Appellant had not followed-up with him since the August 18 meeting.

2.15 On September 16, 1999, Appellant met with Ms. Alvarado-Ramos and discussed GM's issue of isolation and the possibility that GM had a sexual addiction. Appellant did not advise Ms. Alvarado-Ramos that GM was accessing a state line to make unauthorized 1-900 toll calls.

2.16 Appellant asserts that he attempted to follow-up with GM, however, GM's medical file contains no evidence of any intervention or follow-up made by Appellant or his staff. Therefore, we find that a preponderance of the evidence establishes that Appellant failed to provide resident GM with follow-up social services to address GM's feelings of isolation and depression and to prevent GM from continuing to charge 1-900 toll calls to the department, which GM continued to make after August 18.

2.17 Ms. Alvarado-Ramos subsequently learned of GM's misuse of an agency phone line, which totaled an excess of $14,000. On November 30, 1999, the associate superintendent for the Washington Veteran's Home initiated a Personnel Conduct Report (PCR) against Appellant which alleged that Appellant failed to conduct any follow-up visits with GM, failed to report or investigate GM's misuse of the state phone lines, and failed to prevent the resident from continuing in his

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behavior. On January 6, 2000, Appellant met with Ms. Alvarado-Ramos to discuss the allegations. During the course of the meeting, Appellant asserted that he had met with Ms. Alvarado-Ramos and with Ombudsman Karen Taylor on August 18, 1999 and reported to them GM's behavior and abuse of the phone line. To support his contention, Appellant produced a copy of his daily planner on which he had written that he had informed them "of possible phone scam." However, neither Superintendent Ramos nor Ms. Taylor were at the Veteran's Home on August 18, 1999, therefore we find that it was more likely than not that Appellant made a false entry in his daily planner as proof that he reported GM's misuse of the state phone line Ms. Alvarado-Ramos.

Incident involving Resident KG

2.18 On December 21, 1999, resident KG was discovered dead. KG had committed suicide and a subsequent investigation into his death was initiated. The most recent social service documentation in KG's medical file dated back to 1996. KG's file did not contain any updates to his psychosocial assessment or any quarterly social service assessment notes.

2.19 In response to the allegation that KG's file contained no current social service documentation, Appellant asserted that his subordinate had completed a patient assessment for KG in September 1999. However, no evidence of the assessment exists, and we find more likely than not that Appellant failed to ensure that KG's assessment was updated annually and that social services provided were documented in KG's medical chart.

Failure to provide and/or document social services provided in patient medical files

2.20 On January 4, 5, and 6, 2000, Ms. Burster conducted another audit. Ms. Burster reviewed 148 resident medical records. Ms. Burster's audit report reflected that from July 1999 to December 1999, 38 resident charts contained no psychosocial assessment and that 100 resident charts had no social service progress notes.

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2.21 On January 25, 2000, the agency initiated a PCR against Appellant alleging that he failed to ensure that psychosocial assessments and progress notes were completed in compliance with Veteran's Administration guidelines for Assisting Living and Domiciliary Care Standards.

2.22 Appellant disagreed with the findings and asserted that Ms. Burster's review looked at only the social services section of resident charts and failed to review the social work notes entered in the interdisciplinary progress notes. Furthermore, Appellant asserted that he had insufficient staffing to meeting the documenting requirement. As a result, Ms. Ramos directed staff to conduct a review of Ms. Burster's audit.

2.23 Debbie Griswold, Human Resource Consultant, conducted a review of resident records for entire 1999 year. Ms. Griswold looked for any and all notes and entries made by social work staff. Ms. Griswold did not note any significant discrepancy from her review compared to Ms. Burster's audit and Ms. Ramos concluded that Ms. Burster's findings supported that Appellant was not ensuring that progress notes regarding social services provided and psychosocial assessments were documented in resident charts. A preponderance of the evidence supports that Appellant failed complete or ensure that adequate documentation of social services was made in resident charts.

2.24 After reviewing the results of the PCR investigations, Ms. Alvarado-Ramos found misconduct on each of the allegations. In determining the level of discipline, Ms. Alvarado-Ramos reviewed the results of the Personnel Conduct Reports, and Appellant's employment record which included a suspension and several counseling memos. Ms. Ramos concluded that Appellant failed to comply with her expectations and directives regarding care of residents and documenting of social services rendered. Ms. Alvarado Ramos felt that Appellant's failure to ensure that services

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were rendered and documented interfered with department's ability to ensure residents were receiving the requisite care in compliance state and federal care standards.

2.25 Ms. Alvarado-Ramos believed that Appellant's lack of improvement despite prior counseling and discipline, and his failure to conscientiously perform his responsibilities undermined the agency's ability to ensure that residents were receiving a high-level of care and placed the institution at risk of liability. Ms. Alvarado-Ramos concluded that Appellant displayed a pattern of insubordination by failing to comply with her directives; failed to lead by example; failed to ensure that resident's were receiving the necessary social services; failed to ensure that services provided were documented; and failed to be forthcoming and honest with her. Ms. Ramos ultimately concluded that she could not trust Appellant to adequately and responsibly manage the social services department, and she determined that termination was the appropriate sanction based on her findings of misconduct.

2.26 Ms. Ramos also testified that she addressed Appellant's concerns that his department was understaffed, but that audit results showed that he had sufficient staff for the patient population. She also noted that Appellant failed to provide her with supporting documentation to justify an additional social worker.

III. ARGUMENTS OF THE PARTIES

3.1 Respondent argues that Appellant's position demands integrity and that Appellant has proven that he cannot be trusted to perform the duties of his position. Respondent asserts that proper documentation is critical in the care of residents, arguing, "if it isn't documented, it didn't happen." Respondent argues the evidence supports that Appellant did not follow-up or report GM's isolation issues or flagrant abuse of the Home's phone system. Respondent asserts when later confronted, Appellant produced a false entry in his daily planner as evidence that he had in fact

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reported the allegations to the Superintendent. However, Respondent argues that the Superintendent was not at the institution and that Appellant was trying to cover up his own misconduct.

Respondent asserts that there were ongoing and severe deficiencies in the domiciliary and assisted living units and that Appellant continued to deny his accountability and responsibility despite disturbing audit results. Respondent argues that the audits showed that for an extended period of time, residents were not being properly cared for by Appellant and his staff. Respondent argues that Appellant's assertion that social services and care were being provided was not reflected in the documentation. Respondent further argues that staffing was not an issue.

Respondent asserts that a program of progressive discipline was implemented and that Appellant had ample opportunity improve his performance. Respondent argues that given totality of the circumstances, the appointing authority's decision to terminate Appellant was more than appropriate.

3.2 Appellant asserts that Respondent failed to prove that he lied, and he contends that he has always placed the well being of residents in the highest regard. Appellant argues that Respondent failed to prove that he engaged in misconduct or acted in willful disregard the with intent to harm the Home.

Appellant argues that there is no proof that he did not document the GM incident. Appellant asserts that he did provide GM with intervention and follow-up, and that he told the Superintendent about the toll charges the same day he was made aware of the problem. Appellant denies he was untruthful about meeting with the Superintendent and denies he provided her with falsified

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evidence. Appellant asserts that the calendar note he showed to the Superintendent was his attempt to jog her memory about the date they met.

Appellant asserts that his subordinate evaluated resident KG in 1999 and that an annual assessment was completed. Appellant asserts that KG's file contained a signature on an interdisciplinary stamp from a meeting that involved an intense discussion of the resident.

Appellant asserts the evidence the Superintendent relied on to conclude there was a lack of social service documentation was based on audits of Ms. Burster that did not include other sources of documentation in the medical records. Appellant also asserts that Ms. Griswold's audits were incomplete and inaccurate and that documentation had a long history of disappearing from the medical charts. Appellant asserts that the Superintendent failed to hire an additional social worker despite his feedback that social services was short staffed and unable to keep up with the paperwork. Appellant asks that he be fully reinstated to his position.

IV. CONCLUSIONS OF LAW

4.1 The Personnel Appeals Board has jurisdiction over the parties hereto and the subject matter herein.

4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting the charges upon which the action was initiated by proving by a preponderance of the credible evidence that Appellant committed the offenses set forth in the disciplinary letter and that the sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983).

4.3 Respondent has proven by a preponderance of the credible evidence that Appellant failed to provide appropriate social service intervention to address KG's needs; failed to promptly report

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GM's abuse of the state phone; and untruthfully claimed that he met with and reported GM's abuse of the phone line to the Superintendent. Although Appellant understood the importance of providing services, he continued to disregard the importance of placing requisite documentation in resident charts. Appellant had a duty to comply with the standards of the Veteran's Administration and his failure to do so interfered with the department's ability to stay in compliance with state and federal requirements. The record is clear that the lack of proper documentation by social workers was an ongoing issue that Ms. Alvarado-Ramos addressed with Appellant on numerous occasions. Appellant should have understood the implications that a lack of proper documentation had on his department and on the agency as a whole. As a manager, Appellant had a duty to comply with Ms. Alvarado-Ramos' directives and to support the mission of the Washington Veterans Home by ensuring that resident care was documented.

4.4 In determining whether a sanction imposed is appropriate, consideration must be given to the facts and circumstances, including the seriousness and circumstances of the offenses. The penalty should not be disturbed unless it is too severe. The sanction imposed should be sufficient to prevent recurrence, to deter others from similar misconduct, and to maintain the integrity of the program. Holladay v. Dep't of Veterans Affairs, PAB No. D91-084 (1992).

4.5 In assessing the level of discipline, we have considered the totality of the credible evidence and given weight to Appellant's history with the department, and his position of responsibility and authority within the department. We find no reason to overturn Appellant's termination. Appellant has provided no reasons to mitigate his flagrant disregard for failing to follow-up with residents and failing to follow proper procedure and protocol. As the manager of the Social Services Department, Appellant must be held to a high standard of performance and professionalism. Based

on Appellant's prior history of misconduct, his lack of improvement, and under the proven facts of this case, we conclude that Respondent has met its burden of proving that Appellant's misconduct warrants termination. Therefore, the appeal should be denied.

V. ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Steve Erickson is denied.

DATED this _____ day of _____, 2001.

WASHINGTON STATE PERSONNEL APPEALS BOARD

_____
Walter T. Hubbard, Chair

_____
Gerald L. Morgen, Vice Chair

_____
Leana D. Lamb, Member

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